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# Briefing: Behavioral Health Integration in Medi-Cal

February 18, 2020

# Behavioral Health Integration in Medi-Cal

Catherine Teare
Associate Director, High-Value Care
February 18, 2020

# Today's briefing

- Alice Washington, California Institute for Behavioral Health Solutions
- Allison Hamblin, Center for Health Care Strategies
- Panel:
  - Andrew Gruchy, San Bernardino County Department of Behavioral Health
  - Takashi Wada, Inland Empire Health Plan
  - Margaret Kisliuk, Partnership HealthPlan of California
  - Louise Rogers, San Mateo County Health
  - Scott Gilman, San Mateo County Health
- Q&A

# Medi-Cal has a divided behavioral health care system


**Behavioral Health System for Medi-Cal Patients**

**Medi-Cal Managed Care Plans**

Physical health services and mild-to-moderate mental health services

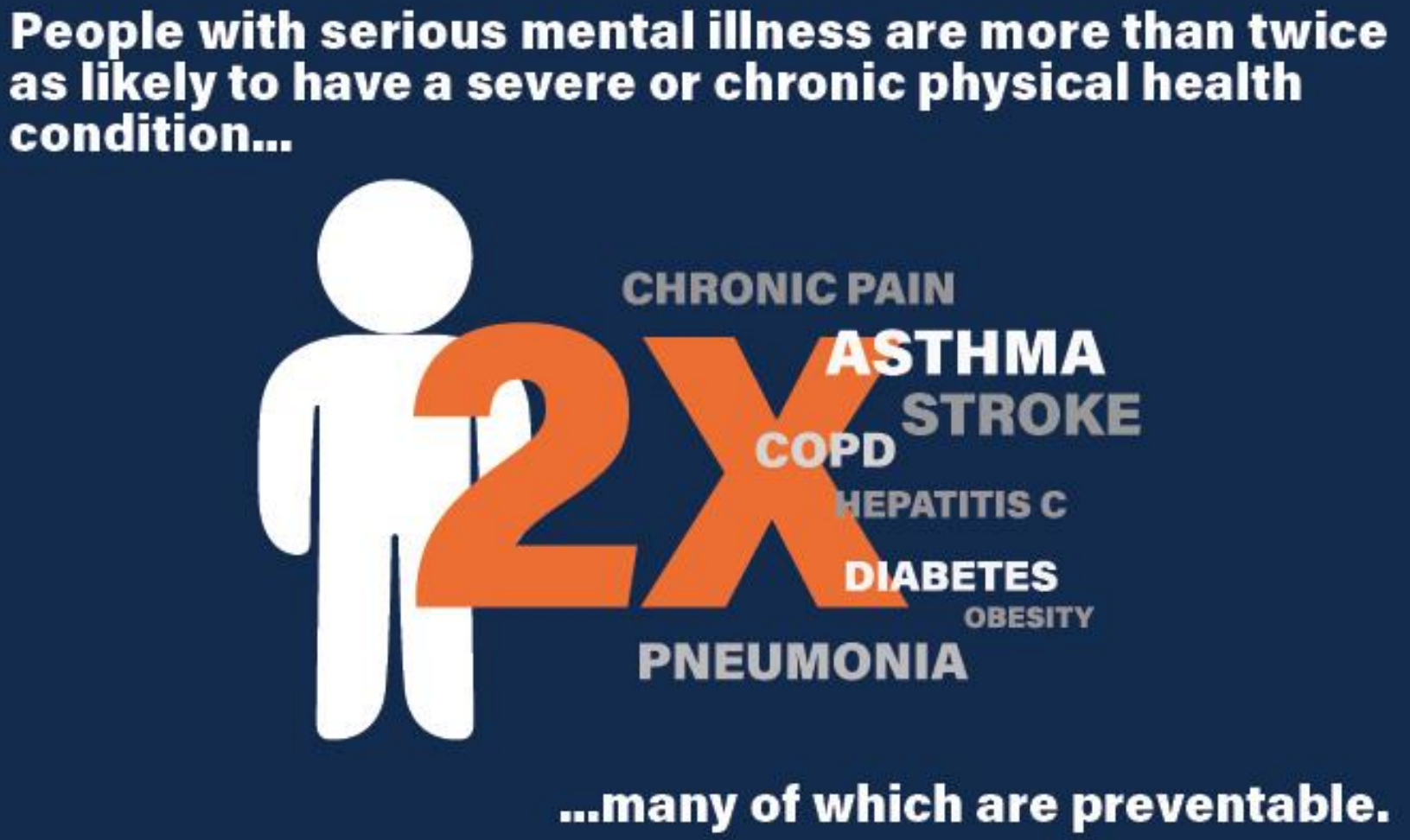
**County Mental Health Plans**

Specialty mental health services for serious mental illness

**County Substance Use Disorder Services**

Services to treat substance use and addiction

# Lack of integration affects access, quality, and consumer experience



# Medi-Cal Healthier California for All proposes significant changes to the behavioral health delivery system

- Behavioral health proposals
  - Behavioral health payment reform
  - Revisions to behavioral health medical necessity
  - Administrative behavioral health (mental health and substance use disorder) integration statewide
  - Behavioral health regional contracting
  - Drug Medi-Cal Organized Delivery System (DMC-ODS) renewal and improvements
  - Institutions for Mental Disease (IMD) expenditure waiver
- Full integration plans

# Integration must take place at multiple levels

## Single point of accountability

## Operational integration

- Data functions: collection, reporting, analytics
- Managed care functions: credentialing, claims, call centers
- Network management

## Financial integration

- Aligned incentives for total cost of care
- Payment structures that support value-based payment

## Clinical integration

- Variety of models: colocation, team-based care, shared EHRs
- Care coordination

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CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

# Behavioral Health Integration: National Landscape Overview

Allison Hamblin, President and CEO

California Health Care Foundation Briefing:
Behavioral Health Integration in Medi-Cal

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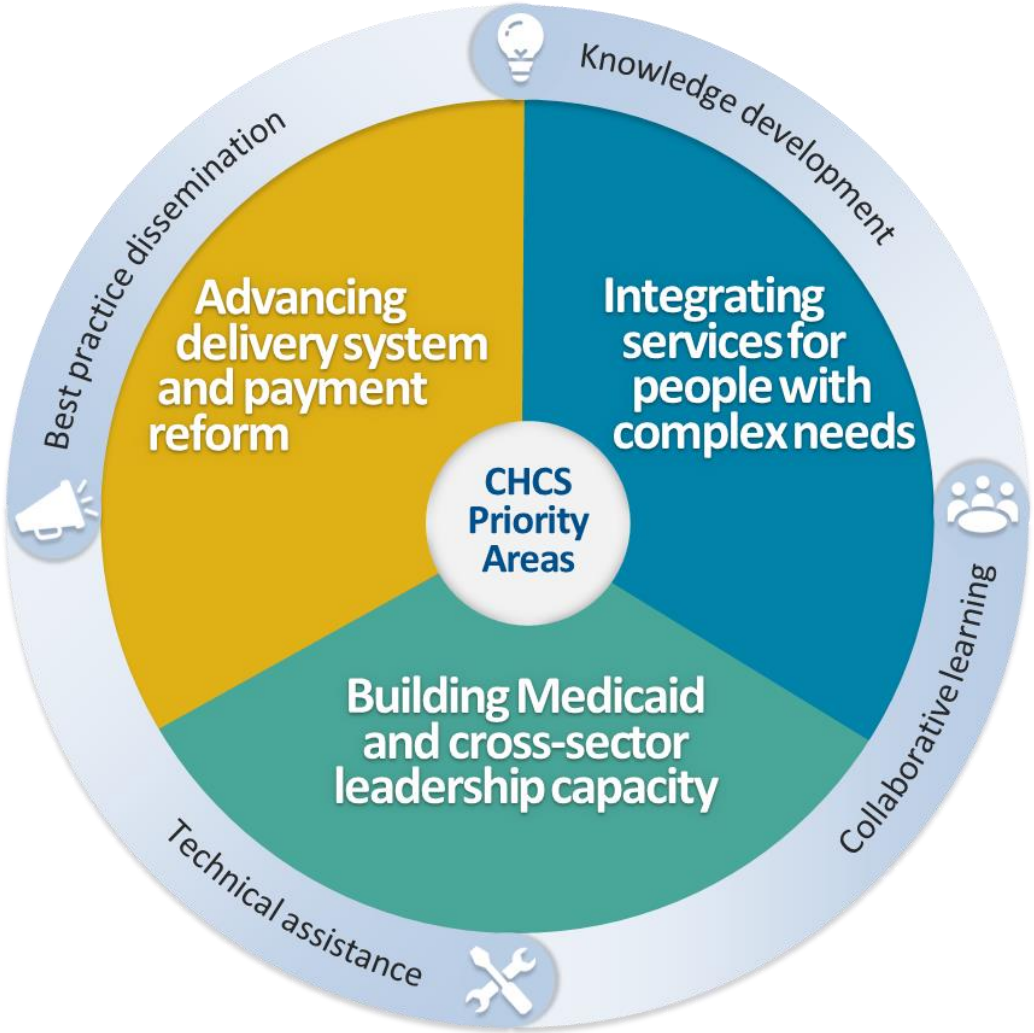
# About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of low-income Americans



# Delivery System Levers to Advance Financial Integration

**Managed Care**

27 states include specialty behavioral health in health plan contracts

**Accountable Care Organizations**

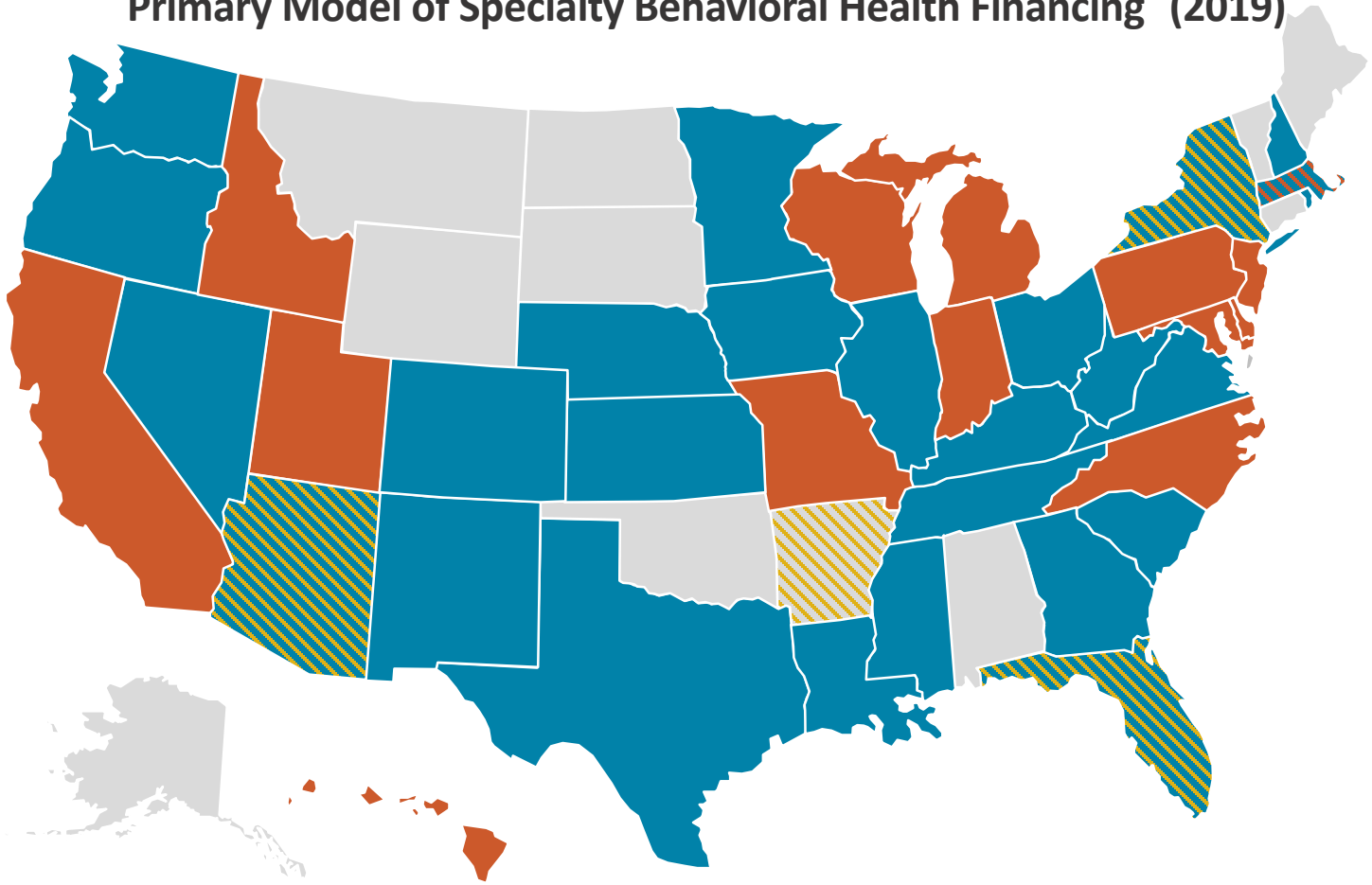
13 states have Medicaid ACOs; subset focuses on physical-behavioral health integration



Sources: Open Minds, "State Medicaid Behavioral Health Carve-outs: The Open Minds 2019 Annual Update," referenced in Institute for Medicaid Innovation, Behavioral Health Coverage in Medicaid Managed Care, 2019; Center for Health Care Strategies, "State Approaches for Integrating Behavioral Health into Medicaid Accountable Care Organizations," 2015.

# Specialty Behavioral Health Financing Models by State

**Primary Model of Specialty Behavioral Health Financing* (2019)**



**Key**

- Integrated financing in managed care organizations
- Behavioral health benefits carved out to behavioral health organizations or to fee-for-service (FFS)
- Physical and behavioral health benefits financed in FFS
- Specialty integrated plans for individuals with serious behavioral health needs

*Note: Some states use different models for different populations. Source: Open Minds, "State Medicaid Behavioral Health Carve-outs: The Open Minds 2019 Annual Update," referenced in Institute for Medicaid Innovation, "Behavioral Health Coverage in Medicaid Managed Care," 2019.

# Outcomes Associated with Integrated Financing

**Arizona:** Adults with severe mental illness (SMI) enrolled in specialty integrated plans showed improvements in all measures related to patient experience, ambulatory care, preventive care, and chronic disease management

- Mixed outcomes with hospital-related utilization measures

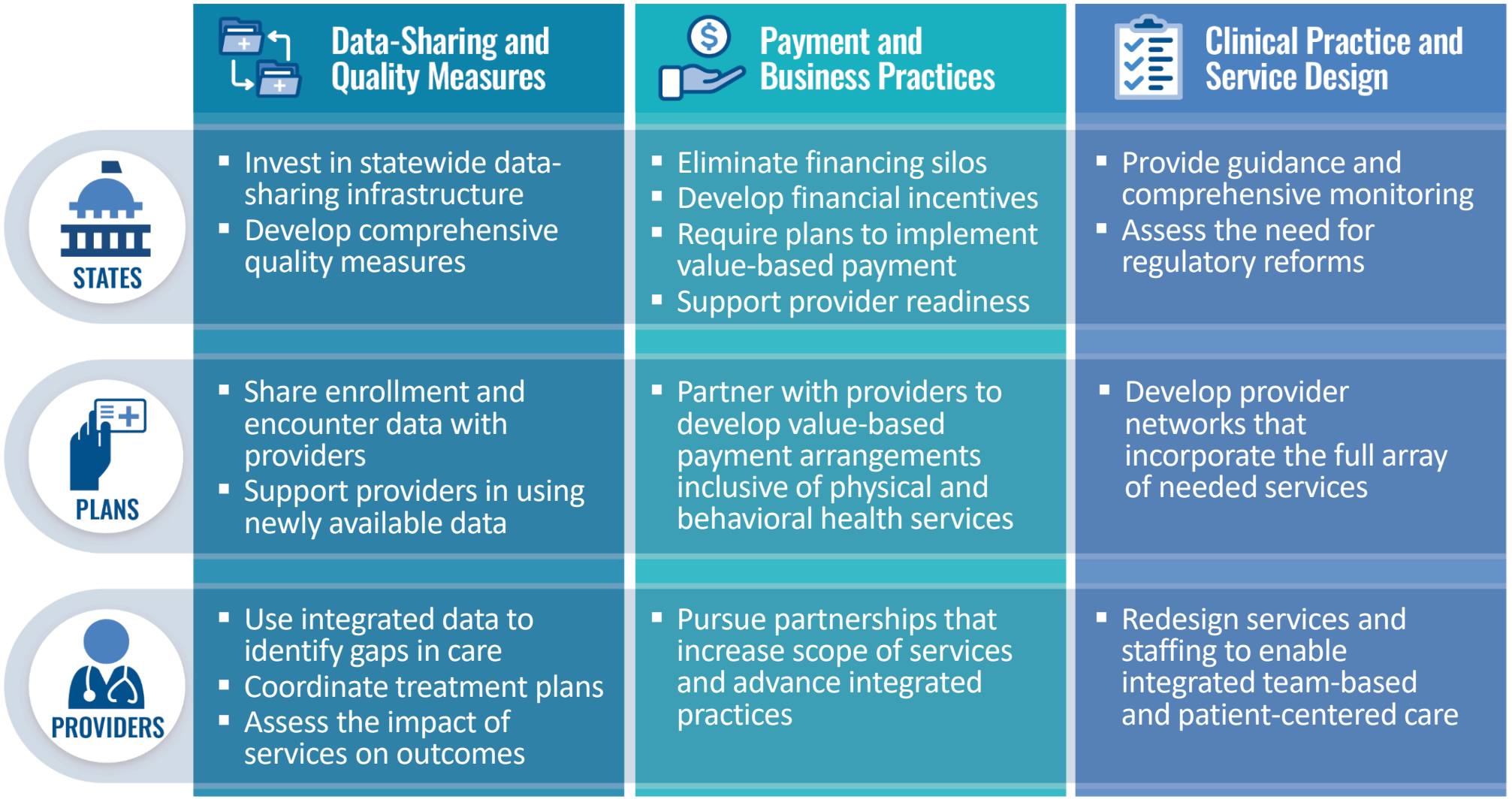
**Washington State:** Enrollees in early-adopter region of fully integrated managed care showed improvements

- Most significant improvement in access to treatment measures, including for those with SMI or SUD
- Modest improvements in quality, coordination of care, and utilization
- Notable improvements in social measures such as homelessness and criminal justice interactions



Sources: Mercer Health & Benefits, "Independent Evaluation of Arizona's Medicaid Integration Efforts," 2018; Washington State Department of Health and Social Services, "Evaluation of Integrated Managed Care for Medicaid Beneficiaries in Southwest Washington: First Year Outcomes," 2019.

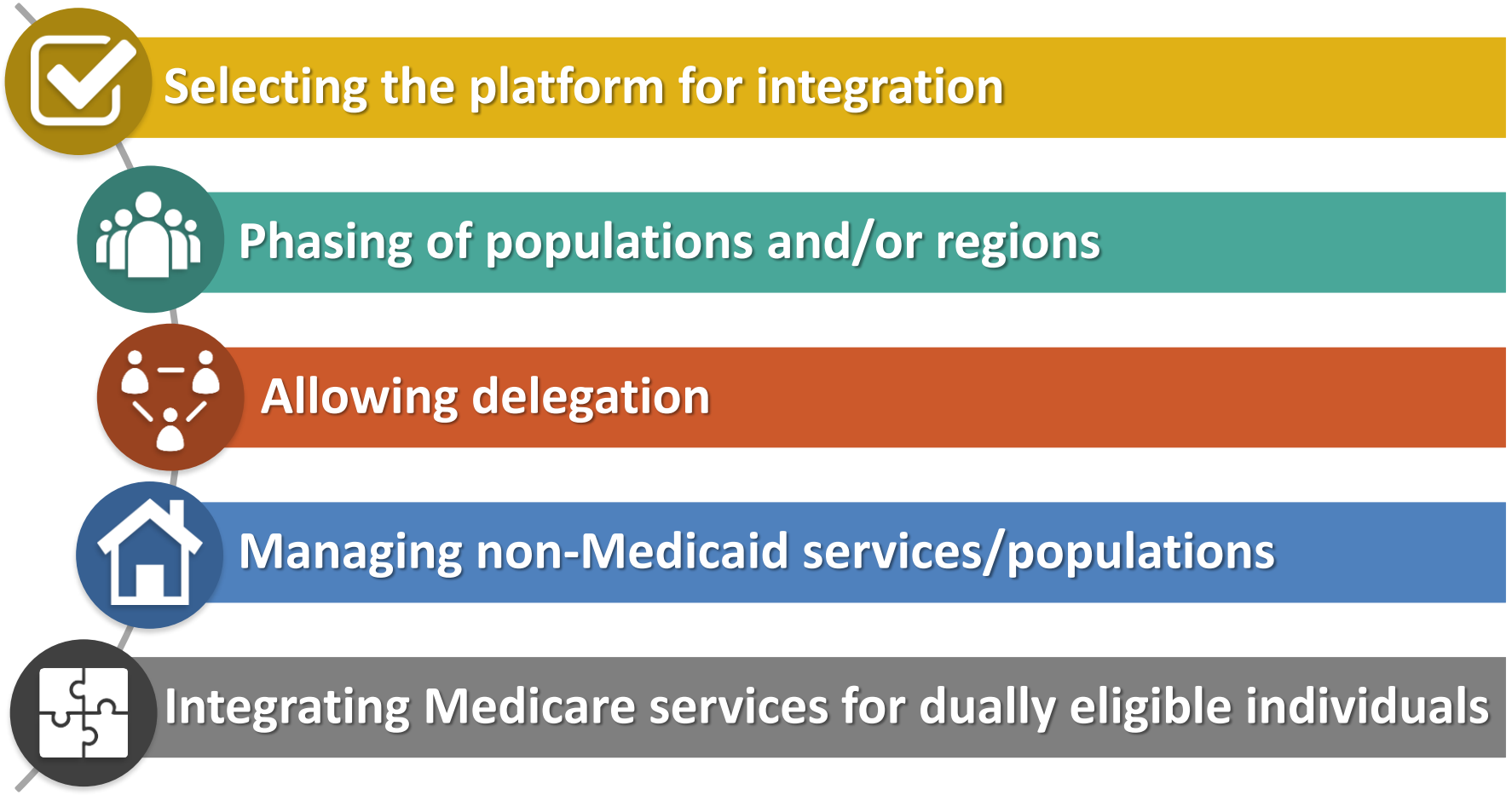
# Levers to Advance Clinical Integration






Source: Center for Health Care Strategies, "Exploring the Impact of Integrated Medicaid Managed Care on Practice-Level Integration of Physical and Behavioral Health," 2019.

# Key Considerations in Designing an Integrated System



# Key Ingredients for Successful Implementation

Engage stakeholders early and often

Employ joint-ownership models

Marry expertise of physical and behavioral health partners

Ensure stable system transitions

Allow adequate time for planning and implementation

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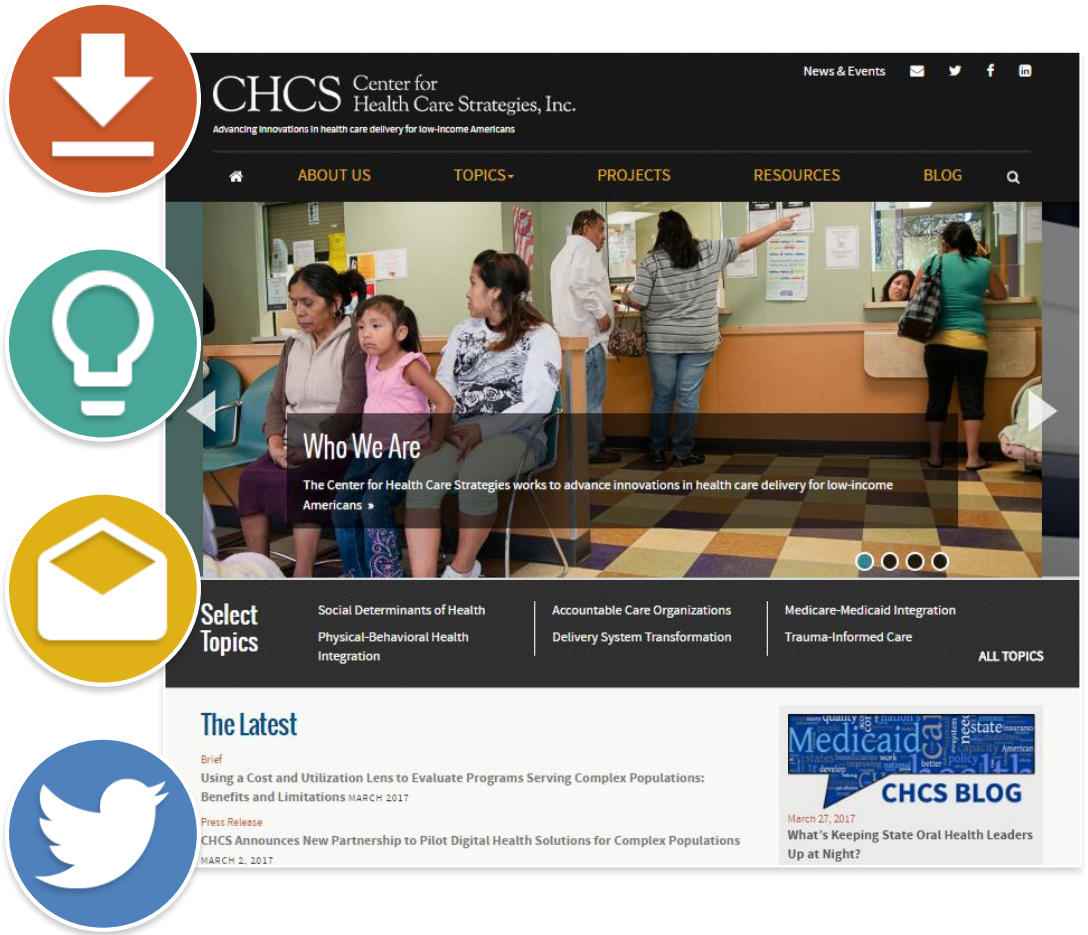

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# Physical and Behavioral Health Integration Pilot

A Joint Pilot with the Inland Empire Health Plan and
San Bernardino County Department of Behavioral Health

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IEHP
A Public Entity
Inland Empire Health Plan

# Why Integrate?

- Current system can lead to poor outcomes for some patients, with many dying decades early often due to treatable physical health conditions
- Patients must navigate multiple complex systems; siloed systems of financing hinder treating all of a patient's health issues
- Limited ability for providers to share patient information and to manage and track referrals, resulting in poor coordination
- Inland Empire Health Plan (IEHP) members who also have an SMI or SUD diagnosis use *twice* as many emergency room and inpatient services compared to other IEHP members

# CURRENT DELIVERY SYSTEM OF CARE

Currently, health services are funded through different sources and offered by different providers, resulting in a complicated system that challenges patient navigation and care coordination, and complicates whole-person care efforts.

**BEHAVIORAL HEALTH SPECIALTY MENTAL HEALTH AND DRUG MEDI-CAL FUNDING**

**PHYSICAL HEALTH SPECIALTY AND MILD-TO-MODERATE MENTAL HEALTH MEDI-CAL FUNDING**

SAN BERNARDINO COUNTY Behavioral Health

**MENTAL HEALTH PLAN AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM**

IEHP A Public Entity Inland Empire Health Plan

**MEDI-CAL MANAGED CARE PLAN**

**SPECIALTY MENTAL HEALTH PROVIDER**

**SUBSTANCE USE DISORDER PROVIDER**

**PHYSICAL HEALTH PROVIDER**

**MILD-TO-MODERATE MENTAL HEALTH PROVIDER**

**Results:** **Fragmented Member Experience** **Inconsistent Care Coordination** **Higher Cost/Poor Outcomes**

# Why Now?

- Integration of physical and behavioral health have long been goals for both IEHP and the San Bernardino County Department of Behavioral Health (SB DBH)
- DHCS's Medi-Cal Healthier California for All initiatives envision an integrated future
- The pilot has the potential to improve outcomes and the patient experience now

# Origins of the Integration Pilot

- Leadership from IEHP and SB DBH convened in April 2019 and agreed to proceed with planning a comprehensive integration pilot
  - Goal: to fully integrate physical and behavioral health (SMI and SUD)
  - A financial arrangement, with shared risk/savings/integration beyond current system seen as practical
  - An evaluation component to share lessons learned
- Workgroups from IEHP and SB DBH organized around care delivery, financing, and communications
  - Teams meet separately in each organization, and jointly, to develop strategy and to proceed with implementation

# The Integration Model: Care Delivery

- Integrated pilot clinics will offer all mental health and substance use disorder outpatient services (including case management)
- On-site primary care providers will be an integral part of the care team and will closely manage patient care in partnership with behavioral health providers and medical specialists
- A standardized referral process will be created for access to specialty physical health services
- Care management / care coordination teams at each clinic will serve those with SMI, chronic physical health conditions, and high utilization of emergency rooms (ERs)/hospitals

# Key Integration Issues

- Addressing *different organizational cultures*, stakeholders, and leadership
- *Developing clinical integration model* by assessing approaches:
  - (1) DBH hires primary care provider, (2) FQHC contract, (3) medical group contract
  - Care management model approach and implementation
- *Sharing data* to model utilization and project costs
- Estimating *costs* (given substantial uncertainty)
  - Primary care costs for SMI population, care coordination costs, potential hospitalization and ER use savings
- *Financing model*
  - How will funding flow? What resources can each organization contribute to the pilot population (e.g., Mental Health Services Act funds, enhanced capitation rate for primary care for SMI population)? How can funds be blended/braided?

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# Partnership HealthPlan of California (PHC) Behavioral Health Services

**Mild-to-moderate mental health services**

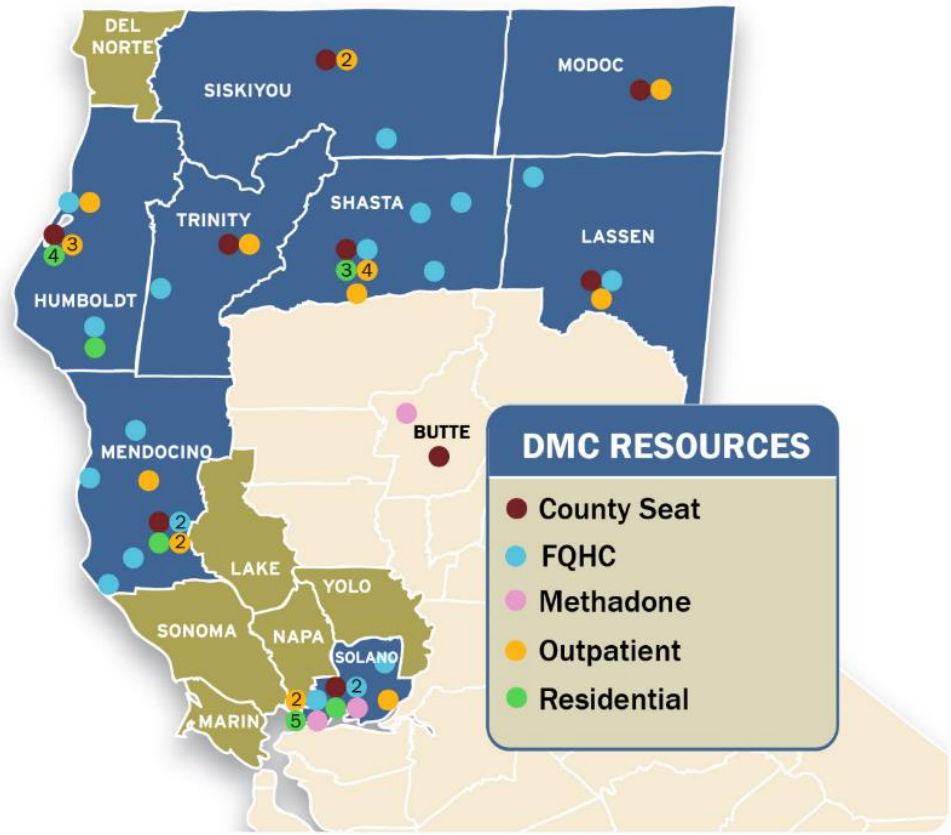
- 8%–9% penetration rate in all 14 counties

**PCPs and others providing MAT**

- Over 100 “X-waivered” providers serving over 5,000 members

**Substance use services**

- 8-county Regional Drug Medi-Cal Organized Delivery System (DMC-ODS); alignment with other counties



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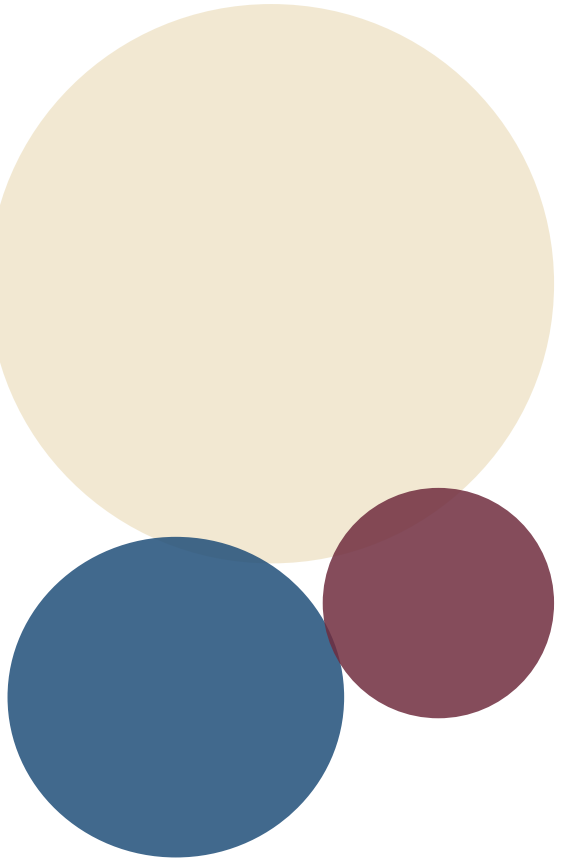
# PHC Regional DMC-ODS: Financial Model

**Overall goal: Maximize state and federal reimbursement, and leverage current PHC services**

1. PHC charges each county a “per utilizer per month” rate based on expected costs and utilization.

2. County will bill share of costs to state and federal governments, and PHC will pay county for services rendered.

3. After a year of experience, a reconciliation will ensure that structure was fair and did not over- or undercharge.





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# PHC Regional DMC-ODS: Service Delivery

## Members

Qualifications

- Medi-Cal coverage
- Meet American Society of Addiction Medicine (ASAM) medical necessity criteria

How members receive services

- Designated agencies (e.g., criminal justice, child welfare)
- Self-referral; no prior approval needed for most services
- Provider referral

## Providers

Two types

- Substance use specific: certified as Drug Medi-Cal qualified by the state
- Current PHC network (e.g., clinics providing medication)

## Service Locations

- Goal of serving clients in their communities as much as possible
- Residential, methadone, and some other services out of county



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Partnering with Health Plan of San Mateo for more than 30 years to help low-income San Mateo County (SMC) residents live longer and better lives.

**What opportunities are we looking for in our next phase of partnership and through the next Medi-Cal waiver?**

Louise Rogers, Chief of Health
Scott Gilman, Director, Behavioral Health and Recovery Services
February 18, 2020

# Who we are

- 765,000 San Mateo County residents
- SMC Health serves 100,000 county residents; delivery system includes public hospital and clinics, behavioral health and recovery services, correctional health, family health, aging and adult, public health; both directly operated and contracted
- Health Plan of San Mateo, a publicly accountable County Organized Health System (COHS), has 130,000 publicly insured members (Medi-Cal, Medicare) plus 21,000 insured on behalf of county
- Easier to try new things in SMC, e.g., first county pilot for specialty carve out for mental health; reimbursement through a case rate model

# Where we've been as a partnership

## SMC Health behavioral health: experience as managed care plan for all publicly insured

- SMC Health Behavioral Health and Recovery Services (BHRS) specialty mental health carve out and Drug Medi-Cal Organized Delivery System for substance use disorders
- SMC Health BHRS delegated behavioral health plan for other lines of business for Health Plan of San Mateo (HPSM) including mild-to-moderate benefits

## SMC Health: experience providing care coordination for high-needs beneficiaries of HPSM

- SMC Health Family Health / HPSM partnership for Whole Child Model (formerly California Children's Services)
- SMC Health Aging and Adult / HPSM partnership for certain high-needs adults, Partners for Independence
- SMC Health BHRS, Public Health, and other divisions all delivering Whole Person Care

## Behavioral health / primary care coordination and integration models within the delivery system, with "back end" coordination

# Where we want to go with our partnership

- Continue working together on delivery system reforms, including partnerships that meet the needs of highest-risk clients (e.g., Whole Person Care)
- Look again at the challenge of meeting increasing back-end requirements that drive the fragmented front-end delivery system experience of our patients — and their results
- Ask whether the managed care functions we are both doing add value to our patients' experience
- Ask where each partner's core competencies are strongest; leverage strengths

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# Where we want to go with our partnership

- Improve beneficiary experience by reducing complexity and the need to navigate multiple systems
- Improve provider experience by reducing complexity and the need to navigate multiple systems
- Align funding, data reporting, quality, and infrastructure to mobilize and incentivize toward common goals across physical, mental, and substance use care
- Maintain accountability for results
- Maximize benefit to low-income residents

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